Department of Laboratory Services Forms

Contents Pg

Herpesvirus Antigen Detection by Fluorescence

Patients Qualifying:

- **All Local Health Department patients**

Specimen:

- **Slide prepared from vesicular fluid collection**

Collection Kit (Herpes FA Slide Kit) Furnished by State Lab Contains:

- **Microscope slide**
- **Styrofoam slide box**
- **Lab Form # 275 Viral Isolation & Immunology**
- **Address label # 356**
- **Instruction Sheet**

Pertussis (Whooping Cough) Agent Detection by Fluorescence

Patients Qualifying:

- **All Local Health Department patients**

Specimen:

- **Slide prepared from nasopharyngeal swab specimen**

Collection Kit (Pertusis FA Slide Kit) Furnished by State Lab Contains:

- **Microscope slide**
- **Styrofoam slide box**
- **Lab Form # 275 Viral Isolation & Immunology**
- **Address label # 356**
- **Instruction Sheet**

Group A Streptococcus Agent Detection by Fluorescence

Patients Qualifying:

- **All Local Health Department patients**

Specimen:

- **Throat Swab (transported in silica gel)**

Collection Kit (Group A Strep Kit) Furnished by State Lab Contains:

- **Sterile Swab for specimen collection with silica gel preservative packet**
- **9" X 7" Manila Envelope**
- **Lab Form # 275- Viral Isolation & Immunology**
- **Address label # 356**
- **Instruction Sheet**

Viral & Rickettsial Serology To Detect Antibody

(see alphabetical "Reference List" for IgG & IgM Serology testing available)

Patients Qualifying:

- **All Local Health Department patients**

Specimen:

- **Serum or Whole Blood**

Collection Kit (Viral & Rickettsial serology Kit) Furnished by State Lab Contains:

- **Sterile Red-stopper tube**
- **Lab Form # 275- Viral Isolation & Immunology**
- **Address label # 356**
- **2-part Mailing Canister -inner & outer canisters**
- **Absorbent material to be provided by submitter**

Viral Isolation

Patients Qualifying:

- **All Local Health Department patients**

Specimen:

- **Throat Swab, Rectal Swab, Spinal Fluid or Tissue as appropriate to clinical symptoms**

Collection Kit (Virus isolation swab) Furnished by State Lab Contains:

- **Sterile Viral Isolation Swab collection outfit ***
- **Lab Form # 275- Viral Isolation & Immunology (Instructions on back)**
- **Address label # 356**
- **Styrofoam Mailer 8" x 5" x 6.5"**
- **Cold Pack**

  *** for non-swab specimens submitter must provide a sterile leak-proof container**

Lab 275 (Rev 4/00)

Kentucky Public Health Laboratory

North Loading Dock
P O Box 2020
Frankfort, KY 40601-2020
502/ 564-4446
Samuel B. Gregorio, Dr. P.H., Director
For hand delivery : 100 Sower Blvd Suite 204

VIRAL ISOLATION
&
IMMUNOLOGY

(Submit white copy with specimen)

Patient Information: **(can use label with complete info)**

Name (Last, First, MI) **please print**

Social Security # Sex EO Age (dd-mmm-yyyy)

Home Address

City

State ZIP County

Send Reports to:

Submitter Name or Facility

Street Address / P O Box

City

State ZIP

Attending Physician's Name (if other than Submitter)

EXAMINATION REQUESTED	SPECIMEN REQUIRED	COLLECTION DATE
Syphilis Serology:		
VDRL	Serum / CSF	_____
FTA-ABS	Serum	_____
(FTA only for diagnostic problems)		
Other Serology:		
TOoxoplasmosis	Serum	_____
Rubella	Serum	_____
CMV	Serum	_____
Herpes	Serum	_____
Measles (Rubeola)	Serum	_____
Varicella	Serum	_____
Mumps	Serum	_____
Other, specify:_____	Serum	_____
Agent Detection:		
Bordetella Pertussis	FA Slide	_____
Herpesvirus	FA Slide	_____
Agent Isolation:		
Streptococcus Group "A"	Throat Swab in Silica Gel	_____
Viral Isolation:	Throat	_____
(Specify Agent Suspected)	Nasal	_____
	Rectal	_____
	Genital	_____
	CSF	_____
	Tissue	_____
	Other_____	_____

CLINICAL DATA

Purpose of request:
diagnostic
immune status
antibody status
other _____

Date of onset _____

	Yes	No
Febrile		
Meningitis		
Respiratory		
Gastrointestinal		
Cardiovascular		
Paralytic		
Pregnant		

(_____ weeks)

Other pertinent info:

Contacts: Unknown
tick bite / date_____
other / date_____

Immunizations / Date
None Unknown
MMR_____ Varicella_____
Influenza_____ Adeno_____
Other _____

********** ***** **DLS Laboratory Findings** ***** **********

Date Received	Laboratory #	Technologist	Date Reported

Serum, 3 ml or Whole Blood, 6 ml	For antibody and/or immune status: submit a single serum For diagnostic determination: ***** by IgM tests - a single serum (a 2nd serum may be requested later) by IgG tests -paired sera: acute phase collect within 7 days of onset of illness. convalescent phase collect 10 to 21 days later.	Ambient or refrigerated temperature
FA Slides for antigen detection	Slides/shippers provided by State Lab.	
Throat Swab (Group A Strep) in silica gel	Swab/mailer provided by State Lab	
Throat Washings	Use 5 - 10 ml sterile Hank's Balanced Salt Solution or sterile saline. 3 or 4 washings from the patient may be pooled in a sterile screw-cap jar. Seal tightly.	Specimens arriving within 24 hours of collection may be shipped refrigerated. If there will be longer storage or shipping times freezing is best. **
Throat Swabs, Rectal Swabs, Vaginal / cervical Swabs	A swab collection outfit is provided by the State Lab but any Viral transport medium is acceptable.	
Spinal Fluid	Submit in a sterile screw-cap tube and seal tightly.	
Feces	Place in a sterile container and seal tightly.	
Vesicle Fluid, or Pustule Crusts,	Collect fluids on swabs and place in 1 ml of liquid (sterile Hank's or saline) in screw-cap container and seal tightly.	
Autopsy Tissues	Place each tissue in a separate sterile screw-cap container and seal tightly. Label each organ.	
Urine, fresh 10 ml	Place in a sterile screw-cap container and seal tightly.	Must be transported to the laboratory within 4 hours.

Specimen Submission: Select appropriate specimens for the clinical symptoms present, collect at proper intervals during illness, and handle as indicated below.

Specimen Required (without preservatives) **Preparation** **Shipping**

***** A significant rise in antibody ratios or titers may determine a recent infection. It is important that there is enough time between acute and convalescent sera to allow for antibody rise. A history of transfusion within 6 weeks of serum collection will invalidate serologic test results.

****** When it is necessary to ship clinical samples frozen, use enough dry ice to last the trip. Seal the sample container with waterproof tape to protect the specimen from the CO_2. Wrap in absorbent material to minimize breakage and to contain any spills.

If the agent suspected is Respiratory Syncytial Virus (RSV) or Cytomegalovirus (CMV) the specimen should be refrigerated but do not freeze. It should arrive at the laboratory within 4 hours of collection.

A completed submission form #275 must be enclosed for each patient !
Dates of specimen collection, and when appropriate, date of onset of illness are required!

Rabies Agent Detection And/Or Isolation To Identify Infection In Animals

Persons Qualifying:

- **All**

Specimen:

- **Animal head**

Collection Kit (Rabies Kit) Furnished by State Lab Contains:

- **Plastic Bucket with Lid-absorbent material to be provided by submitter**
- **Outer Cardboard Shipping Carton**
- **Manila envelope with:**
- **Lab Form # 254- Rabies Examination**
- **Address label # 254F**
- **Instruction Sheet #254d**
- **Plastic Bags & tie fasteners**

Cabinet for Health Services
Department for Public Health
Division of Laboratory Services
100 Sower Blvd Suite 204 Frankfort KY 40601

Lab 254A (Rev 8/99)

RABIES EXAMINATION

Address for hand delivery of specimens only!

Incident Information

Kind of animal: o Dog o Cat o Fox o Skunk o Bat o Raccoon o Other _____

Was animal: o Owned o Stray

Was animal vaccinated? o Yes, date ____/____ o No
day year

Symptoms suggestive of Rabies? o No o Yes_____

County of incident: _____

Reason for Request

Person bitten? o Yes, (name)_____ o Animals exposed_____
(area of body) _____

Person: o Scratched o Licked o Touched o No known exposure

Other human exposure (specify) _____ o Wildlife Survey_____
(county)

Specimen Information

Animal: o Killed o Died (Date:____/____/_____) Packed for shipment: ____/____/_____
day mo year day mo year

Identification

Preference: (Must be a person's name) **Owner** if known, or **Person exposed**

Name: _____ Phone: _ _ _ / _ _ _ - _ _ _ _

Address: _____

City: _____ ST: ____ ZIP:_____ County:_____

Submitting County Health Department: _____

City: _____ Phone: _ _ _ / _ _ _ - _ _ _ _

If applicable: Vet Clinic, or Reference Lab (Ref # _____)

Name: _____ Address: _____

City:_____ ST:____ ZIP:_____ Phone:_ _ _ / _ _ _ - _ _ _ _

All below for DLS use ONLY

Id#:

Received: Lab #:

###

#

Phone Record

Preliminary Report: _____ To: _____

Date / time : _____ By: _____

Confirmatory Report: _____ To: _____

Date / time: _____ By: _____

Lab 254B (Rev 8/99)

Human Immunodeficiency Virus (HIV) Serology

Patients Qualifying:

- **Test available through AIDS counseling and testing sites or Sexually Transmitted Disease Clinics ONLY.**

Specimen:

- **Serum**

Collection Kit (Specify Test) Furnished by State Lab Contains:

- **Lab Form #197 Human Immunodeficiency Virus**
- **Mailing Label: #351 Serology**
- **Mailing container**
- **Red stoppered tube**

Note: Numbered HIV Lab Form #197 and numbered stickers provided by STD Program.

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019
Thomas E. Maxson, Dr. P.H., Director

Please complete a separate form for each specimen. Green copy may be retained by the submitter.

Human Immunodeficiency Virus Serology

C. A

A. K

PATIENT INFORMATION:

Please Use "L" Label or Fill in Completley

Name (Last, First, MI)

Social Security # Sex Race Age Birthdate

Home Address

City State Zip Code County

Send Report To:

Submitter

Street Address (PO BOX)

City State Zip Code

Specimen Information:

Specimen type: ☐ Serum ☐ Whole Blood ☐ Other _____

Date of Collection _____

Program: Has patient been previously tested: ☐ Yes ☐ No

If yes, when *(date)* _____: previous results: ☐ Negative ☐ Positive ☐ Indeterminate

Reason For Testing: (*Mark One*)

Couseling-Testing Site Volunteer
- ☐ Confidential
- ☐ Anonymous

Adult & Child Health Clinic Patient
- ☐ Symptoms suggest HIV Infection
- ☐ Risk factors for HIV Infection
- ☐ TB Patient
- ☐ STD Clinic
- ☐ Person in Custody of Social Services
- ☐ Needlestick Injury
- ☐ Other (prior approval required) _____

Laboratory Findings:

Specimen Unsatisfactory:

☐ Broken in transit ☐ Chylous ☐ Hemolyzed
☐ Insufficient quantity ☐ Laboratory Accident ☐ Other _____

ELISA- Enzyme-Linked Immunosorbent Assay Test:

☐ Non-reactive: No serological evidence of antibody to HIV-1
☐ Repeatedly reactive: Supplemental testing required

Supplemental Test Performed: Western Blot

☐ Non-reactive: No antibody to HIV-1detected
☐ Indeterminate: Testing inconclusive – Please submit an additional specimen in 6 weeks
☐ Reactive: Antibody to HIV-1 detected

Date Received:	Laboratory Number:	Date Reported:	Technologist:

Prenatal Profile

Tests included in Prenatal Profile: ABO, Rh and antibody screen, Syphilis, HbsAg, Rubella

Patients Qualifying:

- **Prenatal Patients**

Specimen:

- **Two full red-stoppered tubes of whole blood**

Collection Kit (Prenatal Profile) Furnished by State Lab Contains:

- **Two sterile red-stoppered tubes**
- **Lab Form: #212 Prenatal Profile**
- **Mailing Label: #359 Prenatal Profile**
- **Inner mailing container, absorbent material provided by submitter**
- **Outer mailing container**

Notes or Comments: Use this profile only when ordering complete profile of tests. See lab form #213 for individual Syphilis, Rubella, Hepatitis, ABO, or Rh & antibodies testing.

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

(Please submit a completed Prenatal Profile Form and two full 7 mL red stoppered tubes per patient.)

Prenatal Profile

Use this form for complete profile only, see Lab Form 213 for individual tests.

Patient Information (Please use L label or fill in completely):

Patient Name (Last, First, MI)

Patient I.D. # Sex Race Age DOB

Home Address

City State Zip County

Submitter Name Submitter Site Code

Weeks Pregnant Antepartum RhoGAM Date Date Collected

Prenatal Profile (ABO, Rh, and Antibodies, VDRL, HBsAg, Rubella) requires two full 7 mL red-stoppered tubes.

FTA-ABS only performed when box below is checked.

☐ Do FTA-ABS if VDRL reactive. (Request only if patient has NO history of reactive FTA-ABS.)

Comments:

For Laboratory Use Only

White copy submitted with specimen • Yellow copy retained by submitter

HBsAg (Hepatitis B surface antigen), Anti-HBs (Antibody to HbsAg), or Anti-HBc (Antibody to HB core antigen)

Patients Qualifying:

- **Prenatal patients, their contacts, and local health department employees (See Notes).**

Specimen:

- **Serum**

Collection Kit (Hepatitus B) Furnished by State Lab Contains:

- **Red-stoppered tube**
- **Lab form #213 Serodiagnosis**
- **Mailing label #351 Serology**
- **Inner mailing container, absorbent material provided by submitter**
- **Outer mailing container**

Notes or Comments: Hepatitis B testing of local health department employees or patients other than prenatal patients should be approved by the Division of Epidemiology prior to testing.

ABO, Rh factor, Antibody Screen

Patients Qualifying:

- Prenatal Patients

Specimen:

- Whole Blood

Collection Kit (Prenatal Profile) Furnished by State Lab Contains:

- Red-stoppered tube
- Lab form #213 Serodiagnosis
- Mailing label #351 Serology
- Inner mailing container, absorbent material provided by submitter
- Outer mailing container

Syphilis Testing

Patients Qualifying:

- All local health department patients

Specimen:

- Serum

Collection Kit (Syphilis serology (single or double) Furnished by State Lab Contains:

- Red-stoppered tube
- Lab form #213 Serodiagnosis
- Mailing label #351 Serology
- Inner mailing container, absorbent material provided by submitter
- Outer mailing container

Special Serologies: *To order one of these tests, mark "other serology" on reverse side and write in test name.*

Test:	Acceptable Specimen:
Candidiasis	Serum, 2 mL or Clotted Blood, 5-8 mL
Cryptococcosis	Serum, 2 mL or Clotted Blood, 5-8n mL or CSF, 1-2 mL
Hepatitis A IgM (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Hepatitis C (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Leptospirosis	Sera, 2 mL each; Acute and Convalescent
Rubella IgM (Prior approval by the Division of Epidemiology required.)	Please call the Serology Section for instructions (502/ 564-4446).
Sporotrichosis	Serum, 2 mL or Clotted Blood, 5-8 mL
Trichinosis	Serum, 2 mL or Clotted Blood, 5-8 mL

Note:

Hepatitis B testing of local heath department patients other than prenatal patients and their contacts must be approved by the Division of Epidemiology prior to testing. Hepatitis B testing of local health department employees other than for determining immune status following immunization and in managing needlestick situations must also be approved by the Division of Epidemiology prior to testing.

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

Please complete a separate form for each specimen.
Yellow copy may be retained by the submitter.

Serodiagnosis

A double sided test order form

PATIENT INFORMATION:

Name (Last, First, MI) _____

Social Security # _____ Sex _____ Race _____ Age _____ Birthdate _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Send Report To:

Submitter _____

Street Address (PO BOX) _____

City _____ State _____ Zip Code _____

Please Use "L" Label or Fill in Completley

Specimen Information:

Date of Collection _____

Specimen type: ☐ Serum ☐ Whole Blood ☐ CSF ☐ Other_____

Purpose of Examination:

☐ Diagnostic
☐ Recheck Specimen
☐ Treatment follow-up
☐ Pre-Hepatitis vaccine
☐ Post-Hepatitis vaccine
☐ Needlestick Injury
☐ Immune Status
☐ Prenatal _____ weeks pregnant
☐ Other, specify _____

Routine Examination Requested:

☐ Rubella IgG
☐ Syphilis testing

Hepatitis B (See note on reverse side)

☐ HBsAg (Surface Antigen)
☐ Anti-HBs (Antibody to HBsAg)
☐ Anti-HBc (Antibody to HB Core Antigen)

Special Examinations

☐ Other Serology, Specify _____

Laboratory Findings:

Dental Fluoride (Supplement Program)

Patients Qualifying:

- **Preschool children without a community fluoridated water supply.**

Specimen:

- **Sample of water supply**

Mailing label:

- **#505b Dental Fluoride**

Collection Kit Furnished by:

- **Dental Program 502/564-3246**

Notes and Comments: Instruction sheet included with collection kit.

Lab 505C
Rev. 1-99

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

(Please complete a separate form for each water supply.)

A.
B. Fluoride Test
For
Supplement
Program

Name of Child(ren): Sex: DOB:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____

Home Address

_____

City State Zip Code

Name of Parent or Guardian:

Send Report To:

_____

Office/Clinic

_____

Street Address (P.O. Box)

_____

City State Zip Code

_____ (_____) _____

County Phone Number

Specimen Information:

Water Supply: ☐ Well ☐ Cistern ☐ City ☐ Bottled Water
☐ Other, specify_____

Laboratory Findings:

___ ___ . ___ ___ **(parts/million) µg/mL**

Date Received:	Laboratory Number:	Date Reported:	Technologist:

Smear exam for Neisseria gonorrheae (GC)

Patients qualifying:

- **All local health department patients**

Specimen:

- **Prepared direct smear from urethral exudate.**

Collection Kit (Gonnorrhea slide) Furnished by State Lab:

- **Slide Mailer**
- **Lab Form # 219 Special Microbiology**
- **Mailing Label: Pre-addressed 3½ x 6½" envelope marked: GO, HAND CANCEL, FRAGILE HANDLE WITH CARE**
- **Instruction Sheet**

Salmonella/Shigella species and other enteric pathogens

Patients Qualifying:

- **All local health department patients.**

Specimen:

- **Stool specimen in "ENTERIC PRESERVATIVE" found in collection kit provided.**

Collection Kit (Enteric pathogens) Furnished by State Lab Contains:

- **Glass bottle, 1 oz., labeled "Enteric Pathogens", containing a preservative**
- **Wood spoon for sampling**
- **Inner mailing container, with absorbent**
- **Outer mailing container**
- **Lab form #219 Special Microbiology**
- **Mailing label #353 Enteric Pathogens**
- **Instruction Sheet**

Notes of Comments: If organisms other than Salmonella of Shigella sp. are suspected please call the Special Microbiology Lab at 502/564-4446 for further instruction or check the Reference Laboratory List.

Intestinal Parasites Examination (See Notes)

Patients Qualifying:

- **All local health department patients**

Specimen:

- **Stool in 10% formalin or**
- **Double vial set of 10% formalin and PVA**

Collection Kit (Intestinal parasites or Intestinal parasites w/PVA) Furnished by State Lab Contains:

- **Glass bottle, 1 oz., labeled**
- **"10% formalin, harmful if swallowed"**
- **Wooden spoon for sampling**
- **Inner mailing container, with absorbent**
- **Outer mailing container**
- **Lab form #219 Special Microbiology**
- **Mailing label #349a Parasitology**
- **Instruction sheet**

Notes of Comments: All stool specimens submitted in 10% formalin are concentrated and examined for intestinal parasites. If the doctor requests the two-vial system, the second vial will contain PVA fixative. A trichrome stain and examination will be performed on stool specimens submitted in PVA fixative. The PVA fixative must be within the expiration date for valid testing. A larger outer mailing container will be necessary to accommodate the double vial system.

Pinworms

Patients Qualifying:

- **All local health department patients.**

Specimen:

- **See instruction sheet provided; Perianal folds impression**

Collection Kit (Pinworm Swube Tube) Furnished by State Lab Contains:

- **Plastic adhesive paddle in a tube**
- **Outer styrofoam mailing container**
- **Lab form #219 Special Microbiology**
- **Mailing label #349a (Pre-addressed 3½ x 6½" envelope marked: PINWORM, HAND CANCEL, FRAGILE HANDLE WITH CARE)**
- **Instruction Sheet**

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019
Samuel B. Gregorio, Dr. P.H., Director

Please complete a separate form for each specimen. Yellow copy may be retained by the submitter.

Special Microbiology

PATIENT INFORMATION:

Name (Last, First, MI) _____

Social Security # _____ Sex _____ Race _____ Age _____ DOB _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Send Report To:

Submitter _____

Street Address (PO BOX) _____

City _____ State _____ Zip Code _____

Please Use "L" Label or Fill in Completley

Specimen Information:

Purpose of Exam _____ ☐ Clinical Specimen

Specimen Source _____ ☐ Referred Culture

Date of Collection _____ Bloody Diarrhea ☐ Ye ☐

No

Examination Requested: *(Please mark one)*

- ☐ Smear Exam for GC
  - ☐ Direct Smear ☐ Smear from Culture
- ☐ Culture Confirmation of Neisseria gonorrhoeae (GC)
- ☐ Intestinal Parasites
- ☐ Pinworm Prep
- ☐ Other _____
- ☐ Enteric Pathogens
- ☐ *Miscellaneous Bacterial Culture

Organism Suspected:

Other pertinent Medical Data: **Please complete this section when submitting Miscellaneous Bacterial Cultures*

FOR LABORATORY USE ONLY:

Date Received:	**Laboratory Number:**

Test	Acceptable Specimen	Preservative/ Comments:
Smear Exam for Neisseria gonorrhoeae (GC)	Direct urethral exudate	None
Culture confirmation of Neisseria gonorrhoeae	Culture on applicable culture media	CO_2 environment
Enteric Pathogens	1. Stool 2. Rectal Swabs 3. Culture on applicable culture media	Enteric Pathogens Kit Please call Special Bacteriology at 502/ 564-4446 for instructions.
Miscellaneous Bacterial Culture	Culture on applicable culture media	Please indicate any pertinent medical data, such as: clinical diagnosis; recent surgery/transplant; animal bites; diabetes, liver disease, etc.
Intestinal Parasites	Stool	10% Formalin
Miscellaneous Parasites	Specimens, such as arthropods, insects, or adult parasites	Please call Special Bacteriology at 502/ 564-4446 for instructions.
Pinworm Prep	See special collection instructions included in state kit.	Adhesive collection paddle, provided in state kit.

Mycobacteriology (TB) Smear & Culture

Patients Qualifying:

- All local health department patients

Specimen:

- Sputum

Collection Kit (TB sputum) Furnished by State Lab Contains:

- Sterile glass 1 oz. Vial with lid
- Inner mailing container, with absorbent
- Outer mailing container
- Lab form #207 MYCOBACTERIOLOGY SMEAR & CULTURE
- Mailing label #355 Pre-Paid, Mycob

Kentucky Health Services Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019
Samuel B. Gregorio, Dr. P.H., Director

Please complete a separate form for each specimen.
Yellow copy may be retained by the submitter.

Mycobacteriology Smear & Culture

PATIENT INFORMATION:

Please Use "L" Label or Fill in Completley

Name (Last, First, MI)

Social Security # Sex Race Age DOB

Home Address

City State Zip Code County

Send Report To:

Submitter

Street Address (PO BOX)

City State Zip Code

Requesting Physician (if other than submitter)

Specimen Information:

Date of Collection _____

☐ **Clinical Specimen**
- ☐ Sputum
- ☐ Bronchial Washing
- ☐ Gastric fluid
- ☐ Urine
- ☐ CSF
- ☐ Other, please specify _____

☐ **Referred Specimen**
Source: _____

Hospital or Laboratory reference number
(if applicable _____)

Is the patient on anti-tuberculosis drugs? ☐ Yes ☐ No

Laboratory Findings:

Date Received:	Laboratory Number:	Date Reported:	Technologist:

Chlamydia trachomatis & Neisseria gonorrhoeae

Patients Qualifying:

- **Family Planning, Prenatal, and STD Clinic Patients**

Specimen:

- **Cervical or Urethral Swab**
- **Specimen must be received in the lab within 7 days of collection. Transport at room temperature**

Collection Kit (Chlamydia – GC (female) or Chlamydia – GC (male)) Furnished by State Lab Contains:

- **Gen-Probe PACE 2 Specimen Collection Kit, specific for cervical or urethral site**
- **Inner mailing container**
- **Lab form #194 CHLAMYDIA TRACHOMATIS & NEISSERIA GONORRHOEAE by Nucleic Acid Probe**
- **Mailing label #194a Chlamydia and GC**
- **Outer mailer (single or multi size)**

NOTE: Please discontinue use of the old single size styrofoam shippers previously used for the Chlamydia and use the double can system for 1-4 specimens or the multi-mailers for up to 17 specimens.

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

Yellow copy may be retained by the submitter.

CHLAMYDIA TRACHOMATIS
and
NEISSERIA GONORRHOEAE
by Nucleic Acid Probe

D. See information on reverse side

PATIENT INFORMATION:

Name (Last, First, MI) *(Codes defined on reverse side)*

Social Security # Sex Age DOB Race/Ethnicity *(circle one)* 1 2 4 5 6 7

Home Address

City State Zip Code County

Please use "L" label or fill in completely

Send Report To:

Health Department

Street Address (PO BOX)

City State Zip Code

Reason For Testing: Did the patient present with Chlamydia/GC symptoms? ❑ Yes ❑ No

Is the patient pregnant? ❑ Yes ❑ No ❑ Unknown

Mark one:
- ❑ Volunteer/Medical Problem
- ❑ Initial (Fam. Plan.) Visit
- ❑ Revisit/Annual (Fam. Plan.)
- ❑ Prenatal Visit
- ❑ Sex Partner Referral
- ❑ Other, please specify_____
- ❑ Unknown/Undetermined_____
- ❑ Cancer

Specimen Information: Source (mark one): ❑ Cervical ❑ Vaginal, post-hysterectomy ❑ Urethral ❑ Other, specify_____

Date of Collection _____ (dd-mmm-yy)

≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈***For Laboratory Use Only***≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈≈

Laboratory Findings:

Chlamydia trachomatis ❑ Negative ❑ Confirmed Positive ❑ Presumptive Positive ❑ Indeterminate ❑ Unsatisfactory

Neisseria gonorrhoeae ❑ Negative ❑ Confirmed Positive ❑ Presumptive Positive ❑ Indeterminate ❑ Unsatisfactory

Remarks:

Date and Time Received: Laboratory Number:

Date Reported: Technologist:

Ethnicity: The Region IV Chlamydia project requires patient ethnicity data using the following codes:

1 White, Non Hispanic
2 Black, Non Hispanic
4 American Indian
5 Oriental
6 Hispanic White
7 Hispanic Black

Test: *Chlamydia trachomatis* & *Neisseria gonorrhoeae* by Nucleic Acid Probe

Specimen: Female Cervical or Male Urethral Swabs collected with the appropriate site specific Gen-Probe PACE 2 Specimen Collection Kit. For information concerning post-hysterectomy specimen collection, please call the Special Microbiology Section at 502/564-4446.

Specimen collection kits are supplied by this laboratory. Only use specimen collection kits within the stamped expiration date. Transport specimens at room temperature. Specimens need to be received in the laboratory within 7 days of collection.

Newborn Screening

Tests for the following are performed in the newborn screening laboratory:

- **Phenylketonuria (PKU)**
- **Galactosemia**
- **Congenital Hypothryoidism (CH) [both T4 and TSH tests are performed]**
- **Sickle Cell**

Patients Qualifying:

- **All infants born in Kentucky.**

Specimen:

- **Whole capillary blood applied to the current lot number filter paper in the manner as described on the back of Lab Form #228.**

Collection Kit (Newborn screening) Furnished by State Lab Contains:

- **Lab Form #228 Newborn Screening.**

MUST be current lot# of form and filter paper. Expiration Date indicates that the form is good through the month and year stated. For example, 04/03 indicates that the form is good through the last day of April 2003. Specimens collected after that date will be Rejected.

- **Mailing Label: None Provided.**

Cost:

- **A charge of $14.50 will be billed for those submitting an initial newborn screen. No charge will be billed for repeat specimens.**

THE NEWBORN SCREENING FORMS, LAB FORM #228, REQUIRES VERTICAL STORAGE IN A COOL, DRY PLACE. DO NOT STORE IN PLASTIC BAGS.

Sickle cell Screening

Tests for the following are performed in the newborn screening laboratory:

- **Sickle Cell**

Patients Qualifying:

- **Prenatal patients and older children.**

Specimen:

- **Whole capillary blood applied to the current lot number filter paper in the manner as described on the back of Lab Form #228.**

Collection Kit (Newborn screening) Furnished by State Lab Contains:

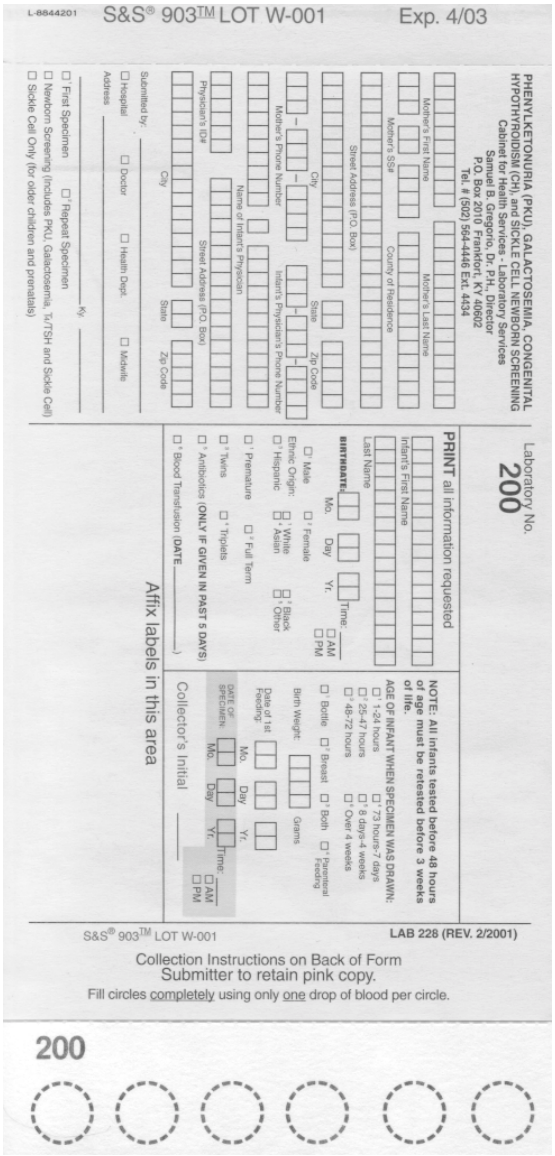
Lab Form #228 Newborn Screening furnished by State laboratory.

MUST be current lot# of form and filter paper. Expiration Date indicates that the form is good through the month and year stated. For example, 04/03 indicates that the form is good through the last day of April 2003. Specimens collected after that date will be Rejected.

Mailing Label: None Provided.

THE NEWBORN SCREENING FORMS, LAB FORM #228, REQUIRES VERTICAL STORAGE IN A COOL, DRY PLACE. DO NOT STORE IN PLASTIC BAGS.

Form available from DLS



L-8844201 S&S® 903™ LOT W-001 Exp. 4/03

PHENYLKETONURIA (PKU), GALACTOSEMIA, CONGENITAL HYPOTHYROIDISM (CH), and SICKLE CELL NEWBORN SCREENING
Cabinet for Health Services - Laboratory Services
Samuel B. Gregorio, Dr. P.H., Director
P.O. Box 2010 Frankfort, KY 40602
Tel. # (502) 564-4446 Ext. 4434

Mother's First Name | Mother's Last Name
Mother's SS# | County of Residence
Street Address (P.O. Box)
City | State | Zip Code
Mother's Phone Number | Infant's Physician's Phone Number
Name of Infant's Physician
Physician's ID# | Street Address (P.O. Box)
City | State | Zip Code

Submitted by: ☐ Hospital ☐ Doctor ☐ Health Dept. ☐ Midwife
Address _____
_____ Ky.
☐ First Specimen ☐ Repeat Specimen
☐ Newborn Screening (includes PKU, Galactosemia, T4/TSH and Sickle Cell)
☐ Sickle Cell Only (for older children and prenatals)

Affix labels in this area

Laboratory No. 200

PRINT all information requested

Infant's First Name | Last Name
BIRTHDATE Mo. Day Yr. Time: ☐ AM ☐ PM
☐ Male ☐ Female
Ethnic Origin: ☐ Hispanic ☐ White ☐ Asian ☐ Black ☐ Other
☐ Premature ☐ Full Term
☐ Twins ☐ Triplets
☐ Antibiotics (ONLY IF GIVEN IN PAST 5 DAYS)
☐ Blood Transfusion (DATE_____)

NOTE: All infants tested before 48 hours of age must be retested before 3 weeks of life.

AGE OF INFANT WHEN SPECIMEN WAS DRAWN:
☐ 1-24 hours ☐ 73 hours-7 days
☐ 25-47 hours ☐ 8 days-4 weeks
☐ 48-72 hours ☐ Over 4 weeks

☐ Bottle ☐ Breast ☐ Both ☐ Parenteral Feeding
Birth Weight: _____ Grams
Date of 1st Feeding: Mo. Day Yr.
DATE OF SPECIMEN: Mo. Day Yr. Time: ☐ AM ☐ PM

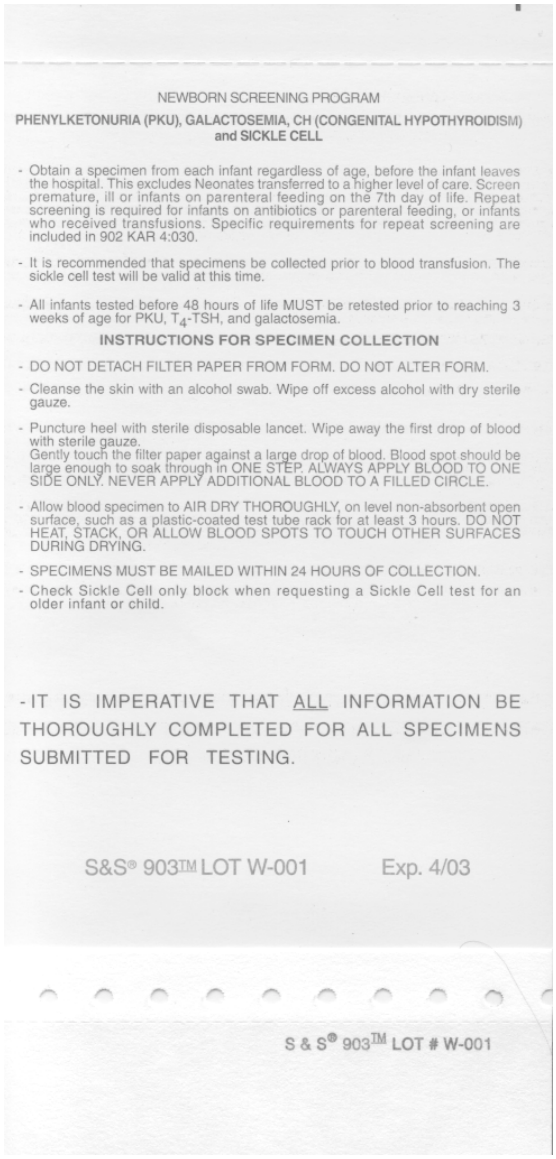
Collector's Initial _____

S&S® 903™ LOT W-001 LAB 228 (REV. 2/2001)

Collection Instructions on Back of Form
Submitter to retain pink copy.
Fill circles completely using only one drop of blood per circle.

200

Front



NEWBORN SCREENING PROGRAM

PHENYLKETONURIA (PKU), GALACTOSEMIA, CH (CONGENITAL HYPOTHYROIDISM) and SICKLE CELL

- Obtain a specimen from each infant regardless of age, before the infant leaves the hospital. This excludes Neonates transferred to a higher level of care. Screen premature, ill or infants on parenteral feeding on the 7th day of life. Repeat screening is required for infants on antibiotics or parenteral feeding, or infants who received transfusions. Specific requirements for repeat screening are included in 902 KAR 4:030.
- It is recommended that specimens be collected prior to blood transfusion. The sickle cell test will be valid at this time.
- All infants tested before 48 hours of life MUST be retested prior to reaching 3 weeks of age for PKU, T_4-TSH, and galactosemia.

INSTRUCTIONS FOR SPECIMEN COLLECTION

- DO NOT DETACH FILTER PAPER FROM FORM. DO NOT ALTER FORM.
- Cleanse the skin with an alcohol swab. Wipe off excess alcohol with dry sterile gauze.
- Puncture heel with sterile disposable lancet. Wipe away the first drop of blood with sterile gauze.
  Gently touch the filter paper against a large drop of blood. Blood spot should be large enough to soak through in ONE STEP. ALWAYS APPLY BLOOD TO ONE SIDE ONLY. NEVER APPLY ADDITIONAL BLOOD TO A FILLED CIRCLE.
- Allow blood specimen to AIR DRY THOROUGHLY, on level non-absorbent open surface, such as a plastic-coated test tube rack for at least 3 hours. DO NOT HEAT, STACK, OR ALLOW BLOOD SPOTS TO TOUCH OTHER SURFACES DURING DRYING.
- SPECIMENS MUST BE MAILED WITHIN 24 HOURS OF COLLECTION.
- Check Sickle Cell only block when requesting a Sickle Cell test for an older infant or child.

- IT IS IMPERATIVE THAT ALL INFORMATION BE THOROUGHLY COMPLETED FOR ALL SPECIMENS SUBMITTED FOR TESTING.

S&S® 903™ LOT W-001 Exp. 4/03

S & S® 903™ LOT # W-001

Back

Cholesterol Screening (Must specify Total Cholesterol or Lipid Profile)

Tests included in Lipid Profile:

- **Total Cholesterol, Triglyceride, HDL, LDL, VLDL**

Patients Qualifying:

- **Family Planning Patients / Chronic Disease Patients**

Specimen:

- **Serum, Lipid Profile requires fasting specimen.**

Collection Kit (Cholesterol/Lipid screening) furnished by State Lab contains:

- **Red stoppered tube**
- **Lab form #230 Clinical Chemistry**
- **Mailing Label #305 Clinical Chemistry**
- **Inner mailing container, absorbent material provided by submitter**
- **Outer mailing container**

Notes/Comments: Please complete the risk Factors Box on the Submission Form for all Chronic Disease Patient testing.

Lithium Level

Patients Qualifying:

- **Patient must have a Comprehensive Care physician's order prior to testing.**

Specimen:

- **Serum**

Collection Kit (Lithium level) furnished by State Lab contains:

- **Red stoppered tube**
- **Lab Form #230 Clinical Chemistry**
- **Mailing Label #305 Clinical Chemistry**
- **Inner Mailing Container, absorbent material provided by submitter.**
- **Outer Mailing Container**

Glucose Tolerance, Prenatal / Postpartum, One hour post 50 gram load Glucose

Patients Qualifying:

- **Prenatal / Postpartum patients**

Specimen:

- **Whole blood collected in sodium fluoride / potassium oxalate gray stoppered tube.**

Collection Kit (Prenatal glucose tolerance) furnished by State Lab contains:

- **Four gray stoppered tubes (one for each specimen)**
- **Lab Form #230 Clinical Chemistry**
- **Mailing Label #305 Clinical Chemistry**
- **Inner mailing container, absorbent material provided by submitter**
- **Outer Mailing Container or Small Styrofoam Box**
- **Cold pack**

Notes / Comments: Please mail all timed tolerance specimens for one patient together with one completed submission form.

Fasting / Random Glucose

Patients Qualifying:

- **Family Planning patients and Chronic Disease patients**

Specimen:

- **Whole blood collected in sodium fluoride / potassium oxalate gray stoppered tube.**

Collection Kit (Prenatal glucose tolerance) furnished by State Lab contains:

- **Four gray stoppered tubes (one for each specimen)**
- **Lab Form #230 Clinical Chemistry**
- **Mailing Label #305 Clinical Chemistry**
- **Inner mailing container, absorbent material provided by submitter**
- **Outer Mailing Container or Small Styrofoam Box**
- **Cold pack**

TEST LIST	SPECIMEN REQUIRED
Total Cholesterol (only)	At least 2 mL of serum (4 mL of whole blood) required.
Lipid Profile Tests included: Total Cholesterol Triglyceride HDL LDL VLDL	At least 2 mL of serum (4 mL of whole blood) required. Specimen must be fasting for reliable results.
Prenatal/Postpartum Glucose Tolerance Test	At least 2 mL whole blood***** per specimen is required. Complete one submission form per patient, mail all tubes together. Specimens must be mailed in an appropriate container with ice pack. *****Sodium fluoride/potassium oxalate preservative is preferred, (gray topped tube).
Plasma Glucose	At least 2 mL whole blood***** is required. Specimens must be mailed in an appropriate container with ice pack. *****Sodium fluoride/ potassium oxalate preservative is preferred, (gray topped tube).

Kentucky Public Health Laboratory
100 Sower Blvd., North Loading Dock,
P.O. Box 2020
Frankfort, Kentucky 40602-2020
Phone: 502/564-4446 Fax: 502/564-7019

Please complete a separate form for each specimen.
Yellow copy may be retained by the submitter.

Clinical Chemistry

PATIENT INFORMATION:

Please Use "L" Label or Fill in Completley

Name (Last, First, MI) _____

Social Security # _____ Sex _____ Race _____ Age _____ DOB _____

Home Address _____

City _____ State _____ Zip Code _____ County _____

Send Report To:

Submitter _____

Street Address (PO BOX) _____

City _____ State _____ Zip Code _____

Specimen Information:

Specimen Collection: Date _____ Time _____ AM PM

Is the patient Fasting: ☐ Yes ☐ No Is the patient Pregnant? ☐ Yes ☐ No

Please fill in for timed glucose specimens as applicable:

Fasting _____ Collection time
2 Hour _____ Collection time
1 Hour _____ Collection time
3 Hour _____ Collection time

Examination Requested: *Must indicate test to be performed. (See Reverse Side.)*

- ☐ Total Cholesterol (only)
- ☐ Lipid Profile
- ☐ Lithium (Patient must have an order from a Comprehensive Care physician prior to testing.)
- ☐ Fasting Plasma Glucose*****
- ☐ Random Plasma Glucose*****
- ☐ Prenatal 1 Hour Glucose*****, Post 50 gm. Load
- ☐ Postpartum Fasting Plasma Glucose*****
- ☐ GlucoseTolerance Test*****, Prenatal / Postpartum *(circle one)*

*****Specimens must be mailed in an appropriate container with ice pack

For Cholesterol and Lipid Profile please indicate the program and mark the risk factors:

PROGRAM : ☐ Family Planning ☐ Chronic Disease

RISK FACTORS:

- ☐ Cigarette Smoker
- ☐ Hypertensive
- ☐ Family History of Premature CHD
- ☐ Diabetes Mellitus
- ☐ Obesity (30% Overweight or Greater)
- ☐ Age 40 or Over
- ☐ Family History of High Cholesterol
- ☐ Sedentary Lifestyle